Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

Respondent Name
DALLAS ISD

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-13-0041-01

MFDR Date Received
SEPTEMBER 10, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary.

Amount in Dispute: $225.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The employee did not submit proof that she has requested reimbursement from the carrier… Likewise, she did not submit documentation showing that she paid $225.00 to certain providers for the health care services… Therefore, the Division should dismiss the employee's request for medical fee dispute resolution."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 12, 2011 October 14, 2011	Office Visits Pharmacy	$225.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.270 sets out the procedures for injured workers' out of pocket expenses for the compensable injury.
3. 28 Texas Administrative Code §134.504 sets out the guidelines for pharmaceutical expenses incurred by the injured employee.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - Neither party submitted EOBs

Issues

1. Did the requestor request reimbursement from the insurance carrier?
2. Did the requestor support that out-of-pocket expenses were incurred?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.270(a) and (b) states that "an injured employee may request reimbursement from the insurance carrier when the injured employee has paid for health care provided for a compensable injury, unless the injured employee is liable for payment as specified in:(1) Insurance Code §1305.451, or (2) Section 134.504 of this title (relating to Pharmaceutical Expenses Incurred by the Injured Employee) and (b)The injured employee's request for reimbursement shall be legible and shall include documentation or evidence (such as itemized receipts) of the amount the injured employee paid the health care provider." 28 Texas Administrative Code §134.504(a) states, "It may become necessary for an injured employee to purchase prescription drugs or over-the-counter alternatives to prescription drugs prescribed or ordered by the treating doctor or referral health care provider. In such instances the injured employee may request reimbursement from the insurance carrier as follows: (1)The injured employee shall submit to the insurance carrier a letter requesting reimbursement along with a receipt indicating the amount paid and documentation concerning the prescription. The letter should include information to clearly identify the claimant such as the claimant's name, address, date of injury, and social security number. Documentation for prescription drugs submitted with the letter from the employee must include the prescribing health care provider's name, the date the prescription was filled, the name of the drug, employee's name and dollar amount paid by the employee. As examples, this information may be provided on an information sheet provided by the pharmacy, or the employee can ask the pharmacist for a print out of work related prescriptions for a particular time period. Cash register receipts alone are not acceptable." Review of the submitted documentation received from the injured worker finds that no documentation was submitted to support the request for reimbursement from the insurance carrier was made.
2. 28 Texas Administrative Code §133.307(c)(4)(H) states that "an injured employee who has paid for health care may request MFDR of a refund or reimbursement request that has been denied. The injured employee's dispute request shall be sent to the MFDR Section in the form and manner prescribed by the division by mail service, personal delivery or facsimile and shall include proof of employee payment (including copies of receipts, health care provider billing statements, or similar documents)." Review of the submitted documentation provided by the requestor finds no receipts or billing statements to support the injured worker paid for medical services.
3. Review of the submitted documentation finds no documentation to support that the services in dispute were paid by the injured worker.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 19, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.